**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name and Address**

SIERRA MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

**Respondent Name**

TASB RISK MANAGEMENT FUND

**Carrier's Austin Representative Box**

Box Number 47

**MFDR Tracking Number**

M4-98-D187-02

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** The requestor did not submit a position statement.

**Amount in Dispute:** $12,373.05

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "TASB originally reimbursed Sierra Medical Center $2,236.00 for two days of surgical per diem, which was the number of days pre-authorized. Review of medical sent by Sierra Medical Center supports continued length of stay. A re-audit has been processed for an additional $2,236.00. ($1,118 daily surgical per diem) which is the fee schedule amount for two additional days."

**Response Submitted by:** Texas Association of School Boards, Inc., P.O. Box 2010, Austin, TX 78768-2010

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 9, 1997 to September 13, 1997 | Inpatient Hospital Services | $12,373.05 | $0.00 |

## *FINDINGS AND DECISION*

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 16, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – Reduction according to fee guidelines
   - G – Included in global charge
   - 524 – Additional documentation needed to process this claim.
   - 530 – Amended audit/No change
   - 531 – Previous recommended amount has been amended as indicated.

**Findings**

1. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).
2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was 4 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 4 days yields a reimbursement amount of $4,472.00. This amount less the amount paid by the insurance carrier of $4,472.27 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | Grayson Richardson | November 21, 2011 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.